

No. 300
10. 48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 4 - 1955

24410

State File No.

1003

Registrar's No. 5759

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) 16	
c. LENGTH OF STAY (in this place) 2 days		d. STREET ADDRESS (If rural, give location) 2246 Lucas-Hunt	
d. FULL NAME OF HOSPITAL OR INSTITUTION New Faith Hosp		f. 000 1	

3. NAME OF DECEASED (Type or Print) Rose	a. (First)	b. (Middle)	c. (Last) Spina	4. DATE OF DEATH (Month) (Day) (Year) 7/1/55
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 11/30/ 1885	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Italy	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Rosario Borrusso	13b. MOTHER'S MAIDEN NAME unk	14. NAME OF HUSBAND OR WIFE Leo Spina
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME Leo Spina	ADDRESS 2246 Lucas-Hunt
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 d
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Hypertensive Cardio-Vascular Disease DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		2 yrs.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Joseph	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 443X
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22. I hereby certify that I attended the deceased from July 1, 1952, to July 1, 1955, that I last saw the deceased alive on July 1, 1955, and that death occurred at 6:24 a.m., from the causes and on the date stated above.

23a. SIGNATURE Joseph B. Guccione M.D.	(Degree or title)	23b. ADDRESS 2801 N. Taylor	23c. DATE SIGNED 7-2-55
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24a. BURIAL CREMATION/REMOVAL (Specify) Burial	24b. DATE 7/4/55	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) (State) St. Louis, Mo
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DATE REC'D BY LOCAL REG. JUL 5 1955	REGISTRAR'S SIGNATURE Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Miceli 1150 N. Kingshiway	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

John S. Denneke

Licensed Embalmer No. *4194*

P. O. Address *St. Louis Mo*

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.